COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
ADULT SYSTEMS OF CARE
CALWORKS MENTAL HEALTH SUPPORTIVE SERVICES

DMH CALWORKS BULLETIN NO. 05-04

GUIDELINES TO AVOID DPSS BILLING EXCEPTIONS

May 23, 2005 (Revised May 30, 2008)

TO: All DMH CalWORKs Mental Health Supportive Services Providers

FROM: Elizabeth Gross, Program Head
CalWORKs Program

SUBJECT: **GUIDELINES TO AVOID DPSS BILLING EXCEPTIONS**

1. PURPOSE

The purpose of this bulletin is to assist providers to bill correctly for CalWORKs mental health supportive services and to avoid billing exceptions when services are delivered to non-eligible CalWORKs participants.

2. BACKGROUND

Under the DPSS reconciliation process implemented in fiscal year 2004-2005 and thereafter, DPSS is verifying that clients receiving CalWORKs mental health supportive services are on its list of eligible CalWORKs participants on the date that services were rendered. If a client is not on the DPSS listing of eligible CalWORKs participants, DPSS will disallow the claim for services and generate a billing exception.

In order to avoid billing exceptions – and the ensuing requirement to reimburse DMH for such services already paid – providers are advised to review the DPSS/GAIN documentation for their CalWORKs participants as well as to review the IS guidelines for data entry affecting CalWORKs billing.

3. BILLING EXCEPTIONS

Billing exceptions occur when services were billed to DPSS for clients who were not eligible for CalWORKs mental health supportive services. As a result of the DPSS billing reconciliation process, DPSS is checking the list of clients served by DMH mental health providers against its list of DPSS/GAIN CalWORKs participants identified on their GEARS system. All billings for CalWORKs mental health supportive services must be for CalWORKs eligible cases only.

A. ELIGIBLE CALWORKS PARTICIPANTS

CalWORKs mental health supportive services billed to DPSS must be authorized by DPSS/GAIN and a supportive services component opened on the LEADER/GEARS system by a GAIN Services Worker. Providers can bill mental health services only for those participants who are:

(1) Enrolled in GAIN with a signed Welfare-to-Work Plan and are in compliance;

(2) Exempt from GAIN, but have volunteered for GAIN and a supportive services component has been opened by the GSW for the participant as an Exempt Volunteer (EV);

(3) Timed-out, but have requested continuing mental health services and a Post Time-Limited (PTL) supportive services component has been opened by the GSW for the participants; OR

(4) Post-employment participants who are receiving services up to one year after being employed and terminated from CalWORKs, and have notified DPSS that they wish to receive post-employment supportive services (PES).

When DPSS identifies clients that do not fit into any of the above categories, DPSS generates a billing exceptions list and requests that DMH obtain written documentation to support the claim.

B. REASONS FOR BILLING EXCEPTIONS

A billing exception is generated when a DMH provider bills for a client that is not on the DPSS/GAIN list of CalWORKs participants. The reasons may be categorized as follows. The examples given are not exhaustive, and there are several possible examples why the client was not eligible.

(1) Client may have been eligible, but DPSS/GAIN never authorized services by opening up a mental health supportive services component.

Examples:

- Provider sent in a PA 1923 (Treatment Services Verification) but never received a written response to the PA 1923 via the GN 6149 (CalWORKs PA 1923 Results Notification) or other written notice.
- Client never had a CalWORKs mental health services component added to his/her Welfare-to-Work program.
- Provider made the client exempt, but the client did not volunteer for GAIN so that a mental health supportive services component was never opened up for him/her.
- Client timed-out, but client never notified DPSS/GAIN he/she wanted to continue receiving mental health services and consequently, a supportive services component was never opened.

(2) Client was eligible and had a mental health supportive services component open, but became ineligible during treatment.

Examples:

- Client was approved for SSI while on CalWORKs, but provider failed to stop billing CalWORKs.
- Client was sanctioned and a notice of termination (GN 6011 Termination Notice) was sent by DPSS, but provider failed to stop billing CalWORKs.
- Client became employed full-time and was terminated from CalWORKs, but post-employment services were not requested.

(3) Client was never eligible.

Examples:

- Client was under 18 years of age.

- Client was GROW eligible, not CalWORKs eligible.
- Client was exempt from GAIN (e.g., client received CalWORKs cash aid, but never had a Welfare-to-Work Plan requirement).
- Client was always Medi-Cal eligible only (e.g., client was employed, received no cash aid, but received Medi-Cal benefits).

5. VERIFICATION OF CALWORKS ELIGIBILITY

The first step to avoid a billing exception is to check the client's eligibility for CalWORKs services the very first time the treatment provider meets with the client. This means that each CalWORKs participant must have at least one of the following documents when the case is opened, or very shortly thereafter. These forms are the provider's supporting documentation that the client is in fact a CalWORKs participant eligible for mental health supportive services.

(1) Client referred by the CASC Service Advocate
- GN 6006A
- GN 6006B

(2) Client referred by GAIN
- GN 6006B

(3) Existing client on provider's caseload (backdoor referral)
- PA 1923 and GN 6149 Notification
- PA 1923 and letter from DPSS/GAIN indicating the client is eligible for CalWORKs supportive services.

(4) New client walk-in (backdoor referral)
- PA 1923 and GN 6149
- PA 1923 and letter from DPSS/GAIN indicating the client is eligible for CalWORKs supportive services

6. MEDI-CAL AID CODES

All CalWORKs participants are Medi-Cal eligible and can receive traditional Medi-Cal services. Participants that choose not to inform their GSW that they are receiving mental health services can continue to do so and will have their services paid by Medi-Cal if they meet medical necessity criteria. All CalWORKs participants have Medi-Cal aid codes assigned to them, depending on their eligibility and status during a given month. In general, Medi-Cal aid codes of 30 and 35 are a good indicator that the client is eligible for CalWORKs supportive services, but a Medi-Cal aid code of 30 or 35 does not guarantee eligibility for CalWORKs mental health supportive services. Other transitional aid codes are frequently noted. However, eligibility must be verified with the GSW.

7. CHECKING CLAIMS ON THE IS

Providers are advised to review their CalWORKs claims submitted on the IS on a monthly basis, at a minimum. This review will enable agencies to note any discrepancies in billing at an early date, so that corrective actions can be taken. Below is a list of common mistakes that occur on the IS when claiming for CalWORKs mental health supportive services.

A. DATA ENTRY

- No social security number (SSN) entered or an SSN of 888-88-8888 or 999-99-9999 entered. A valid SSN is required in order for DPSS to match the case. Without an SSN, DPSS eligibility cannot be verified for reimbursement.
- Client is under 18 years of age. Providers can bill CalWORKs only for adults age 18 years and older.

B. CLIENT ENROLLMENT IN CalWORKs PLAN

- Client not enrolled in the CalWORKs Plan. The IS requires that each client be enrolled in a plan; the default plan is CGF (County General Funds). If the client is not specifically enrolled in the CalWORKs plan, the claims will default to CGF.
- Contract agency or DMH clinic/program not authorized to bill CalWORKs. Only those CalWORKs contracted agencies and directly operated clinics/programs approved by DMH CalWORKs Administration may enroll clients in a CalWORKs plan and provide services to CalWORKs participants.
- Client no longer eligible for CalWORKs. When a client's eligibility changes, providers should also change the plan enrollment to the appropriate plan, removing CalWORKs as the payer source. The participant should be terminated from the CalWORKs plan on the IS (performed on the Administrative functional area – update enrollment). If the provider is still seeing the client, the new payer and plan must be identified.

C. BILLING PROBLEMS

- CalWORKs client services were billed to Medi-Cal. Medi-Cal is a payer, not a plan; CalWORKs is a plan and the payer is DMH.
- Non-authorized CalWORKs procedure codes were used. For example, COS case management support (procedure code 6000) is not authorized by CalWORKs. The DMH CalWORKs Bulletins No. 04-01 (Procedure Codes for CalWORKs Services) and No. 05-02 (New

Approved CalWORKs Procedure Codes) list the procedure codes that are authorized for CalWORKs participants. Only the listed procedure codes can be used to bill for CalWORKs services.

- Agency is not authorized to bill for the service. This occurs when an agency bills for mental health services that are not in its DMH contract. The provider may bill only for those services that have been approved in the provider's contract. For example, psychological testing requires special approval.
- Double billing. Data is entered twice.
- Amount of time (UOS and service time) is excessive. This may indicate an entry error.

8. CORRECTIVE STEPS

As soon as a problem with a claim is identified, providers should take corrective action to resolve the issue. Some common errors are described below:

- Claim incorrectly billed to Medi-Cal.
  If a claim was incorrectly billed to Medi-Cal and the claim has not yet been approved and/or sent to Medi-Cal, the provider should:
  (1) Void the original claim, and
  (2) Submit a new claim by re-entering the data correctly.*

  If the claim was incorrectly billed to Medi-Cal and the provider has already been paid, the provider must:
  (1) Void each and every claim sent to Medi-Cal, and
  (2) Submit a new claim by re-entering the data correctly.*

  If a provider chooses not to void the Medi-Cal Claim and not to submit a new claim, then these services will not be reflected in the agency's CalWORKs billing and will not count against their CalWORKs allocation.

- Claim incorrectly billed to CGF or other plan.
  (1) Void the original claim, and
  (2) Submit a new claim by re-entering the data correctly.*

- Ineligible participant.
  If a claim was submitted for an ineligible client (e.g., SSI recipient or child), the provider should
  (1) Void the incorrect claim, and
  (2) Reenter the claim and submit it against the correct plan.*

** Verify with DMH's Revenue Management the timeframe for Medi-Cal claim deletion/voiding and resubmission.*

9. REVIEWING IS REPORTS

Providers are encouraged to review the IS reports for their agency on a regular basis to check that claims are being entered correctly. Some questions to ask when reviewing the IS reports include:

- Does the report list all the agency's CalWORKs clients?
- Are there clients on the list who are not CalWORKs?
- Is a valid social security number listed for each client?
- Is the Medi-Cal ID number listed?
- Is the person 18 years and older?
- Is the client receiving SSI?
- Are there double entries for the same service?

10. SUMMARY

In order to avoid billing exceptions, it is recommended that providers:

► First, check that the client is eligible for CalWORKs mental health supportive services at the time of intake, or submit a PA1923 and review the GN 6149 to verify eligibility shortly thereafter. Providers should stay in regular contact with the GSW regarding eligibility status and submit the GN 6008 (progress report) every three months as required.

► Second, follow the IS policies and procedures to input data correctly for mental health services for eligible CalWORKs participants enrolled in a Welfare to Work plan. Make sure the participant is enrolled in the CalWORKs plan.

► Third, review the IS reports on a regular basis for any errors or omissions.

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